KENTUCKY MEDICARE SUPPLEMENT COMPARISON STATEMENT

Current Insurance _____ Annual Premium _____
(Insurer Name)

Proposed Insurance _____ Annual Premium _____
(Insurer Name)

MEDICARE (PART A): HOSPITAL INSURANCE - COVERED SERVICES PER BENEFIT PERIOD (1)				PRIVATE INSURANCE CHECKLIST	
Services	Benefit	Medicare Pays*	You Pay*	Current Insurance Pays (Plan)**	Proposed Insurance Pays (Plan)
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $	$		
	61st to 90th day	All but $ a day	$ a day		
	91st to 150th day***	All but $ a day	$ a day		
	Beyond 150 days	Nothing	All costs		
POSTHOSPITAL SKILLED NURSING FACILITY CARE In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge (2).	First 20 days	100% of approved amount	Nothing		
	Additional 80 days	All but $ a day	$ a day		
	Beyond 100 days	Nothing	All costs		
HOME HEALTH CARE	Visits limited to medically necessary skilled care.	Full cost of services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment		
HOSPICE CARE Available to terminally ill.	Up to days if doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.		
BLOOD	Blood.	All but first 3 pints	For first 3 pints.****		
FOREIGN TRAVEL	Medically necessary emergency care in a foreign country.	Emergency hospital services in qualified Mexican or Canadian hospitals.*****	All costs not covered by Medicare		

* These figures are for 20___ and are subject to change each year.

** If the policy being replaced is not a standardized policy, insert "N/A" after "Plan" and complete this column.

*** 60 reserve days may be used only once; days used are not renewable.

**** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

***** Please refer to your Medicare Handbook for more information.

(3) A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.

(4) Medicare and private Medicare supplement insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): HOSPITAL INSURANCE - COVERED SERVICES PER CALENDAR PERIOD				PRIVATE INSURANCE CHECKLIST	
Service	Benefit	Medicare Pays	You Pay	Current Insurance Pays (Plan)*	Proposed Insurance Pays (Plan)
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $ deductible)	$ Deductible** plus 20% of balance of approved amount (plus up to 15% above approved charge)***		
HOME HEALTH CARE	Visits limited to medically necessary skilled care	Full cost of services; 80% of approved amount for durable medical equipment (after $ Deductible).	Nothing for services; 20% of approved amount for durable medical equipment (after $ deductible).		
AT-HOME RECOVERY BENEFIT	Short-term at-home assistance with activities of daily living.****	Nothing	All costs		
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80% of approved amount (after $ deductible).	Subject to deductible plus 20% of approved amount.		
BLOOD	Blood	80% of approved amount (after $ deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount (after $ deductible)*****		
PREVENTIVE CARE-PATIENT EDUCATION	Annual physical exam, preventive testing, influenza vaccines	Screening pap smears once every 3 years; screening mammograms every 24 months.	All costs not covered by Medicare		
*******OUTPATIENT PRESCRIPTION DRUGS	Outpatient prescription drugs	Nothing	All costs		
FOREIGN TRAVEL	Medically necessary emergency care in foreign country.	Doctor and ambulance service in Canada and Mexico if in connection with covered inpatient	All costs not covered by Medicare		
OTHER******					

* If the policy being replaced is not a standardized policy, insert "N/A".

** Once you have had $ of expense for covered services in 20___, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

*** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.

**** At home recovery benefits must be received in conjunction with Medicare approved home health care benefits.

***** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

******Use this area to compare pre-standardization and/or innovative benefits.

*******Medicare Supplement insurers cannot offer prescription drug coverage after January 1, 2006. Prescription drug coverage will be offered through Medicare.

NOTICE TO APPLICANT:
Do not sign this form unless it has been explained to you.

Applicant: Date: Agent: Date:

NOTICE TO AGENT/INSURER:
This form is to be retained by the replacing insurer and attached to the replacement policy.